# Toward a new way of relating: An evaluation of recovery training delivered jointly to service users and staff

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## Introduction

Whilst a recovery focus has been promoted at a policy level in the UK (Social Care Institute for Excellence et al, 2005; Shepherd et al, 2008), there has been relatively little exploration of how to change the culture of practice on the ground –particularly the exploration of training that could facilitate a cultural shift towards the Recovery model. Perhaps the most fundamental shift that is required is from a paradigm where practitioners see themselves as experts and service users are expected to comply with what is asked of them, to one in which service users set their own direction and practitioners work alongside them as their allies (Slade et al, 2009). This implies a very different approach to working relationships and practitioners' use of self.

This paper explores an innovative approach to training in which the medium of delivery – as much as the actual content that was delivered – challenged the conventional construction of professional relationships. Whilst there has been a growing body of literature on mental health training delivered by trainers with lived experience of mental distress (McAndrew and Samociuk, 2003; Tew et al, 2004; Khoo et al, 2004; Fadden et al, 2005; Spencer et al, 2011) there has been only limited research into models of recovery training for staff (Slade et al 2009; Gudjonsson et al, 2010). This paper looks in detail at a pilot Recovery training

programme that was not only facilitated *by* people with lived experience, but was also delivered *to* a mixed group of practitioners and service users – a configuration that has been tried to a limited extent elsewhere (Doughty et al, 2008; Higgins et al, 2010). Such a configuration provides further opportunities to break down barriers and disrupt the implicit constructions of 'them' and 'us' that can underpin much of conventional professional practice – but which may be seen as inimical to a form of practice which is about being an ally in the recovery process rather than delivering treatment or care. Additionally, the participants in this training programme were service users together with the practitioners who normally worked with them and would continue to do so. The study focuses on staff experiences of the training and the impact on their practice.

**Recovery**

Central to Recovery are values regarding a person's right to build a meaningful life for themselves, with or without the continuing presence of mental ill health (Anthony, 1993). Recovery is based on self-determination and self-management and, crucially, emphasises the importance of hope in sustaining motivation and supporting a person's expectations for an individually fulfilled life (Shepherd et al, 2008). However, the development of recovery oriented practice has been sporadic in the UK and the understanding of its concepts remains limited, despite its adoption within government and by key professional and policy organisations (Social Care Institute for Excellence et al, 2007). It is therefore suggested that workforce training and development is fundamental to the rollout of a recovery orientation and that all sectors of the mental health workforce

require training to enable them to work within a framework that supports the empowerment of consumers (Boardman and Shepherd 2011).

Slade Luke and Knowles (2009) piloted evaluation methodologies for recovery training and noted a significant gap between the implicit concepts of recovery and current clinical practice. Recovery requires a different relationship between service users and professionals - users being central to the recovery process without invalidating the opinions and judgement of professionals (Alexander, 2008). Therefore, recovery training must reflect this and help staff make the attitudinal shifts needed to work within emerging constructs. More importantly, this mode of training can demonstrate and reinforce a collaborative paradigm of interaction, where service users are no longer situated as passive recipients of care and treatment delivered by professionals, but are related to as experts in their own right, based on their situated understanding of their own experiences (McAndrew and Samociuk, 2003; Tew et al, 2004).

**Training Programme**

The training pilot was designed by trainers with lived experience of mental ill health, who had previously worked in mental health services and written extensively on recovery. It comprised 3 one day workshops using concepts from the THRIVE Approach to mental wellness (Aslan and Smith, 2007). The sessions were aimed at educating workers to help people reach turning points, giving practical ways for managing self-harm, voice hearing and risk issues, and

instilling recovery values of hopefulness and optimism. There was an overall focus on using collaborative and person centred approaches to develop self-esteem, resilience and interdependence with others.

Throughout the sessions the trainers drew on their own personal and professional experiences as a way of facilitating the sharing of experiences and narrative accounts within the group, from both staff and user perspectives. In relation to these narratives, a systematic approach was taken to identify links between ill health and life events, and what may be potential turning points on personal journeys towards recovery, Ways of reframing experiences were then explored with consideration of personal beliefs and regaining self-control, the development of peer support and a sharing of coping strategies which staff and service users could follow up on after the training had finished.

These sessions were advertised to a range of community mental health services and were open for staff and service users to attend, with staff encouraged to ask service users they were currently working with to attend with them. In total, 10 staff and 7 service users attended one or more of the sessions, averaging 12 participants per session. All but one of the participants had not undertaken any previous recovery training and all service users had long term diagnoses of psychosis.

## Evaluation Methodology

While other studies have explored the immediate impact of recovery training using larger cohorts and a pre- postevaluation methodology (Higgins et al, 2012), this pilot offered the opportunity to follow up a small sample of participants six months after the training, thereby offering time for reflection and to assess whether or not any changes had become embedded in practice. Permission for the study was granted by the Trust research department on the proviso that only staff were interviewed, unfortunately limiting the opportunity to assess changes from a service user as well as a practitioner perspective.

The final sample of four participants was chosen on the basis of maximising diversity, with representation from Community Mental Health, Assertive Outreach and Crisis Resolution teams, and a range of professional backgrounds, including: Nursing, Support staff and Occupational Therapy. All were based at different locations. Although a semi-structured approach was used in order to obtain consistent data, following Wengraf (2001), additional follow-up questions were used to give the interviewer freedom to explore emergent themes during the interview. The interviews were taped and transcribed.

## Data Analysis

Thematic analysis is a form of pattern recognition within the data where emerging themes become the categories for analysis (Boyatzis, 1998; Fereday

and Muir-Cochrane, 2006). The approach taken was an iterative one, involving the identification and distillation of themes through careful reading and re-reading of the data.

The first stage of analysis was to read through each individual interview, highlighting quotes and comments allowing for tentative themes to be considered. Initially the data was grouped according to the five topic areas of the interview schedule (Table 1).

Table #1

The next stage involved the identification of emergent themes across each of the five categories, and noting the frequency of comments made in relation to each. Starting with a more extensive list of seven possible themes, those themes that encompassed relatively few comments were incorporated into related or overlapping themes which had captured more responses. Out of this process, four key themes emerged, into which all of the comments could be then allocated; these were Power Relationships; Barriers/Resistance; Feeling Safe / Opening Up as a Person; and Inspiration / Transformative Learning (Table 2).

Table #2

**Findings**

Overall, interviewees were very enthusiastic about the impact of the training on their practice – although certain cautions were expressed. In analysing their responses, particular themes emerged.

***Theme 1: Power Relationships***

Repper and Perkins (2003) suggest that the most effective way of challenging discrimination and the power differentials that exist between professionals and service users is by direct contact between the two groups, enabling both to come together on equal terms. All the interviewees made positive comments about collaborative working and learning together, for example:

> "*Good to have the opportunity to work collaboratively. We always talk about working with clients in partnership and this was a really good example.... we could share experiences with each other*" (Interviewee 1).

The interviewees commented that the process of the training (particularly through the trainers sharing their lived experience) created a sense of equality in the workshops. For some, this enabled them to reflect on the implicit power relations within 'the system' when viewed from the perspective of service users:

> *"It was good to have both staff and service users there; service users gave their opinion of how the system is in their eyes – it puts things into perspective on how you treat them"* (Interviewee 2).

One participant noted that the training had raised their awareness of the power dynamics that exist in service delivery - commenting that staff can act paternalistically and realising how traditional approaches to care can involve the overprotection of service users which may cause disempowerment.

All participants reported that this had led to them to adapt their practice, establishing more collaborative ways of working with service users on their caseloads (and not just with those service users who had participated in the training).

***Theme 2: Barriers and Resistance***

Interviewees seemed unwilling to own any of their own resistances, tending to talk instead about potential barriers that they imagined might exist for service users or other staff. This apparent diffidence in facing such issues directly accords with the experience of Slade et al (2009) that sensitivity may be required when encountering resistance and potential barriers - as the adoption of a recovery approach can be an unsettling experience for both staff and service users, particularly if confidence is low.

Concerns were expressed that service users may have been disappointed, when learning together, to discover that staff did not 'know it all' - with one participant noting,

"*Service users may think, "Why don't they know this already?*"" (Interviewee 3).

It was suggested that some staff may be uncomfortable learning about mental health in the company of service users, who may question their experience and skills. One participant developed this perception further, commenting that using person centred recovery tools that enable service users to link their voice hearing

to their past experiences may raise anxieties in staff who may not feel capable in managing what may be opened up by such a process.

Other staff expressed concerns that their peers may perceive the training with scepticism, not accepting the notion of 'experts by experience' and preferring to learn from clinical experts in mental health. One interviewee considered the potential arrogance of some of their peers, commenting that they would likely reject the validity of being taught by service users, thinking "*what could they teach me*?" (Interviewee 3)

Alongside this, some of the interviewees raised concerns that many service users may not be "*at the level"* (Interviewee 4) where they can engage in such a training process – either because they are not sufficiently far forward in their own recovery journeys or because recovery, in the sense of no longer needing services, might not be a realistic goal for them. While this may indeed be a potential barrier from a service user perspective, it may also be that these perceptions are, at least in part, born out of apprehension and fears of staff, experiencing recovery concepts in practice themselves for the first time. This may be indicative of the power dynamics that continue to exist in their work environments where the culture is not recovery oriented.

***Theme 3: Feeling Safe / Opening up as a person***

All interviewees noted the enabling effect of the trainers sharing their own experiences of ill health and recovery as a way of offering empathy and understanding - expressing surprise at how swift and effective this was:

> "*The fact they had experiences themselves… just immediately set the scene where people felt comfortable and they were able to relate to people in that way*." (Interviewee 1)

This had encouraged openness within the group, not only allowing service users to feel safe to describe their experiences with increasing confidence, but also opening up the possibility for staff to feel "*able to share our experience freely*" (Interviewee 3) .

As another participant explained:

> *"What we could talk about were some of the limitations and difficulties we have and where we (as professionals) fall short of how to be helpful. I think it gives both parties the chance to understand the other's perspective and can be quite enlightening for us".* (Interviewee 1)

All interviewees commented that the training helped remind them that they were working with people rather than with symptoms experienced by people, "*it reminds you that we are all individuals…"* (Interviewee 2). Some also commented that the training may help service users to get to know professionals better, "*maybe see me as a person, not necessarily as someone who is there to help them"* (Interviewee 2). Two of the interviewees described how acknowledging their own experiences of ill health could have a positive impact when supporting others, one participant stating:

*"I think we have all got an experience to share and I think it [the training] encourages us to be able to share our experience freely… I haven't yet found an example of any time when it hasn't been successful".* (Interviewee 1)

The value of such open disclosure and dialogue across professional boundaries has been acknowledged elsewhere (Higgins et al, 2012) with the resulting 'shared humanness' making a crucial difference to user experiences of services and to promoting their possibilities for recovery (Holley, 2007).

***Theme 4: Inspiration / Transformational Learning***

Transformational learning is a very different process from the more conventional acquisition of knowledge and skills: it involves fundamental shifts in attitudes, identities and relationships – and there are strong parallels between this and the sorts of turning points that service users may go through on their journeys towards wellness (Aslan and Smith, 2007). It is suggested that such learning may be facilitated by a 'horizontal student-teacher relationship', working from the assumption that all participants have something valuable to contribute and a focus on learning from experience (Taylor, 1998) – all of which would seem to have been present within this training experience.

Interviewees reported that the trainers' sharing of their personal experiences and recovery stories had been inspirational, challenging prior identities as 'professional' or 'service user' and the expectations around a 'doing unto' service culture that can go along with these. They were surprised by the positive effect this had on the service users at the workshops. They noted that the openness in

the group had encouraged service users to see links between their experience and that of others, highlighting the potential of peer support. Alongside this, two respondents acknowledged the value of service users being able to share negative experiences with the group, exploring how services may sometimes have impeded their ability to recover.

Following the joint training experience, interviewees reported that participant service users had begun to re-evaluate their view of themselves in relation to their mental health. They noted that, six months on, these service users were reporting improvements in self-confidence and taking active responsibility for personal wellness as opposed to reliance on others. For some, the experience would seem to have been instrumental in helping them to break out of the service user role, for example deciding to take on college courses with the view to volunteering and working within services.

These apparent transformational shifts in attitude among service user participants were also echoed in the reported experience of staff participants. One participant with no prior exposure to recovery ideas reported that:

> "*What I really took away was what service users are really going through… I never really thought about that before*." (Interviewee 2)

Others reported that the training gave them a deeper understanding of service users' experiences and the impact of these on behaviour. They learned how to use service users' narratives to guide their understanding of their experiences,

noting how "*an over clinical perspective can miss everyday distress*" (Interviewee 4).

**Discussion**

This preliminary exploration of participant experiences suggests a potentially transformational impact on working relationships when staff had the opportunity to explore notions of recovery jointly with the service users with whom they were working. This "served to challenge professional orthodoxies and power" (Higgins et al, 2012 p. 7), creating an arena for mutual understanding in which staff could move out of more paternalistic roles and service users became more confident to assert their own perspectives.

A catalyst for learning was the trainers sharing their lived experience of mental illness. This facilitated a sense of trust and openness that supported the learning experience, reflecting Taylor's (1998) discussion of positive learning environments. Collaborative interaction occurred, leading to less of a sense of self-definition based on role relationships and more of a sense of coming together as human beings – a way of working that, once internalised, could potentially be replicated when working with other service users in the future.

Although this study has focussed on practitioners' experiences, other evaluations have shown similarly positive outcomes of joint leaning for service users and family members (Doughty et al, 2008; Higgins et al, 2012) – and the indications

are that this training was also successful in inspiring service user participants to move forward in their own lives.

However, this study reflects the experience of a small sample from a cohort of staff who had been motivated to put themselves forward for the training, and there was no opportunity to directly assess outcomes for service users. It would therefore be helpful to undertake further research with larger samples to explore whether this is a model that could work with all staff and service users, or whether it may only be applicable to staff who are already favourably disposed towards a recovery orientation in their work, and to service users who have already reached 'a certain level' in their personal recovery journeys. Given the cautions identified by participants, we should also be aware that this model of joint training could raise anxieties among staff or service users.

**Implications for Future Development**

The findings from this study indicate that a model of recovery training that involves staff, *and* the service users with whom they work, can be transformative for participants. Conducting the research six months after completion of the training gives some indication that these changes can be sustainable, at least in the short term. However, as has been argued elsewhere, implementation of recovery focused practice requires not just training initiatives, but also a

fundamental culture change within organisations. “overcoming the traditional biomedical approach, and shifting the philosophy of care from the present preoccupation with illness to one of wellness” (Higgins et al, 2010 p 65).

Recognising this, interviewees articulated some concerns that should be borne in mind if such a model of training were to be rolled out more widely. As other studies have shown (Slade et al, 2009), adopting more collaborative approaches to working together can be anxiety provoking for both staff and service users – perhaps particularly for staff who are familiar and comfortable with occupying the ‘one up’ position of professional expert, and service users who may not yet be in a place where they feel able to take more control over their lives. It may therefore not be appropriate to employ this approach ‘from cold’ with staff or service users who have had little prior exposure to what a recovery approach might mean for them – or little inclination to engage with such a potentially transformational process. It may require careful planning and appropriate support to be put in place, and for this to be located within a wider strategy for changing organisational culture (Boardman and Shepherd, 2011).

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